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ABSTRACT

Some theoreticians believe that diagnostic and prognostic impressions are based in part on clinicians' personal values. A study was conducted to assess whether clinical judgment is affected by patient religiosity, therapist religiosity, or an interaction between patient and therapist religiosity. Psychotherapists' (N=15) judgments concerning religious clients were investigated by comparing ratings of similar religious and nonreligious patient vignettes on the dimensions of appropriateness, selection, impairment, prognosis, diagnosis, required therapy sessions, and likelihood of continuation. Independent and interaction effects of therapists' own religiosity, as measured by scales of affiliation, belief, and nondoctrinal attitudes, were also examined. The results revealed that, regardless of their own religiosity, all therapists rated religious patients less favorably regarding diagnosis and required sessions. Regardless of the religiosity of the patient, therapists with strong religious beliefs assessed fewer therapy sessions. An interaction was found indicating that nondoctrinally religious therapists had more favorable prognoses for religious patients. (Author/NB)

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Effects of Religiosity of Therapist and Patient on Clinical Judgment

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Abstract

Psychotherapist's judgments concerning religious patients were investigated by comparing ratings of similar religious and nonreligious patient vignettes on the dimensions of appropriateness, selection, impairment, prognosis, diagnosis, required therapy sessions and liklihood of continuation. Independent and interaction effects of therapists' own religiosity, as measured by scales of affiliation, belief and nondoctrinal attitudes, were also examined. One hundred fifteen subjects participated. ANOVA and regression analyses were used. Regardless of their own religiosity, all therapists rated religious patients less favorably regarding diagnosis, and required sessions. Regardless of the religiosity of the patient, therapists with strong religious beliefs assessed fewer therapy sessions. An interaction was found indicating that nondoctrinally religious therapists had more favorable prognoses for religious patients.

Effects of Religiosity of Therapist and Patient on Clinical Judgment

According to some theoreticians, diagnostic and prognostic impressions are based in part on clinicians' personal values. Some say that patients whose values diverge from their therapists are likely to receive harsher diagnoses and poorer prognoses. Religion as a source of bias has come under increasing scrutiny, especially since demographic studies have found that psychologists as a group are less religious than the general population, and presumably the patients they serve.

Two recent studies by Wadsworth and Checketts (1980) and Lewis (1983) attempted to find out whether psychologists' diagnostic or prognostic judgments are influenced by their own or their patients' religious affiliations. Both found no such biases. The purpose of this clinical analogue study was to try to expand upon and refine the method of earlier ones, in assessing whether clinical judgment is affected by (1) patient religiosity, (2) therapist religiosity, or (3) an interaction between these.

Patient religiosity was presented to therapist-subjects in narrative vignettes depicting either a depressed woman or an obsessive compulsive woman. Each of these vignettes came in two conditions, religious and nonreligious. Each pair differed only in their last paragraphs where either religious beliefs and activities or corresponding secular beliefs and activities were presented. For example, the religious obsessive patient said she had a "feeling that things happen according to God's plan" and had social contacts only with members of her religious congregation. The similar nonreligious patient had a sense that "things happen for the best" and had social contacts only with other members of her university department.

Method

Subjects

Subjects were recruited at poster sessions of the American Psychological Association's 1984 Annual Convention in Toronto. They volunteered in response to the experimenter's posted sign. Of 119 respondents, usable data were collected from 115. All were Ph.D.s. All were at least part time psychotherapists. 52% were men, 48% were women. Their mean age was 38.1 years with an average of 6.4 years of postdoctoral psychotherapy experience.

Dependent Measures

The psychologists filled out a 9-question schedule of therapists prognostic expectations (STPE) (Graham, 1980) for each of the two patient vignettes they evaluated. The schedule requires the clinician to rate patients on a 7-point Likert scale for appropriateness for therapy, selection for the therapist's caseload, severity of impairment, motivation to change, capacity for insight, liklihood of making substantial progress in therapy, diagnosis, and an estimate of number of sessions that the patient will actually attend.

Independent Measures

Each subject then filled out three different scales of religiosity. The first scale measures religious affiliation, was developed by Lenski (1963), and asks about the respondent's attendance at regular religious services and other congregational activities. The second scale measures traditional religious belief, was developed by Brown and Ferguson (1968), and asks respondents about their comparative need for a religious orientation, whether they believe in a personal, omniscient, omnipotent God who created the universe, and how strongly they hold their beliefs. The third scale measures nondoctrinal religion, was devised by Yinger (1969), and is based on his idea that religion is a

humanwide experience that rests on some common substructure independent of differences in rite and belief. Respondents are asked whether they consider religion a valuable effort to deal with the human situation, whether they value difficult experiences as a source of increased understanding, whether they think that beliefs can serve as effective coping mechanisms in dealing with difficult experiences and whether they believe that there is some underlying order and pattern to human existence.

Results

As expected, the subject-therapists' religiosity was different from that of the general population. Fifty-five percent of them said they believed in God and 47% identified themselves with a traditional religion. The corresponding figures for the general population are 90% and 68% respectively (American Institute of Public Opinion, 1978).

Following a factor analysis, some items on the STPE were grouped into a single dependent variable, while other questions were retained as individual variables. The three measures of therapist religiosity were treated as continuous. A two-way ANOVA with repeated measures was employed to analyze relationships between subjects' ratings of patients and patient religiosity. Simple regression analyses were used to analyze relationships between the therapists' religiosity and any differences between their ratings of the two experimental groupings of patients, i.e., religious and nonreligious.

Taken as a homogenous group, without taking into account their personal religiosity, the therapists diagnosed the religious patients as significantly more severely ill than the nonreligious patients, $F_{1,113}=34.31$, $p<.01$, and felt that the religious patients would need significantly more therapy sessions to make substantial progress than the nonreligious patients would, $F_{1,113}=26.31$, $p<.01$. They expressed

no preference to work with the nonreligious over the religious patient when the primary diagnosis was depression, but had a significant preference for the nonreligious patient when the primary diagnosis was obsessive compulsive disorder, $F_{1,113}=5.06$, $p<.05$.

The therapists' personal religiosity affected their judgments of all patients, religious and nonreligious alike, in one instance. As the clinicians' traditional religious beliefs increased, their assessment of the number of therapy sessions required by patients decreased, $F_{1,113}=4.86$, $p<.05$.

One significant interaction between therapist and patient religiosity was found. As therapists' nondoctrinal attitudes increased, their overall prognoses of religious patients became more favorable, $F_{1,113}=5.67$, $p<.05$, and significantly better than their prognoses for nonreligious patients, $t(113)=2.34$, $p<.05$.

Conclusions

The results of this study differ from those of earlier studies. First, therapist religiosity was found to influence some clinical judgments. Earlier studies may have missed this phenomenon because they used affiliation as the sole criterion of therapist religiosity. This study confirms that affiliation is not a source of therapist bias. Rather it was clinicians' underlying religious beliefs and attitudes that influenced their judgments.

The other finding of this study that differs from earlier ones is that therapists, as a homogenous group, do have some biases against religious patients. They diagnose them more severely and recommend for them a greater number of therapy sessions. One previous study (Wadsworth and Checketts, 1980) may not have gotten this result because the patient religiosity presented to therapists consisted of a simple statement of denominational affiliation. Just as beliefs and attitudes

and not affiliation, are sources of therapist bias, so therapists probably discriminate against religious patients only when the patient's religiosity is evident in expressed beliefs and actions, not mere affiliation. The prior study that did present patient religiosity in the form of religious language (Lewis, 1983) and did not find biases may have been limited by its presentation of a single type of patient pathology, i.e., depression. This study confirmed that therapists view patient religiosity in the context of specific pathology and as a less serious complicating factor when a patient is depressed than when she is obsessive compulsive.

That therapists holding traditional religious beliefs recommend fewer sessions for all their patients may be due to those therapists' preference for briefer therapy models that are action oriented and focus on guilt, responsibility and conscious choices (Mowrer, 1960). Marx and Spray (1969) concluded from their study that religious apostates more than religious adherents are likely to engage in the practice of intensive individual psychotherapy; they see intensive psychotherapeutic models (e.g., psychoanalysis) and religion as alternative and competing bases of personal commitment and identification.

The findings that nondoctrinally religious therapists have better prognoses for traditionally religious patients and that the same is not necessarily true for therapists who hold traditional religious beliefs or are affiliated with traditional religions is problematic. Perhaps Yinger's (1969) scale does tap most directly that superempirical system of faith and hope that often underlies but does not necessarily imply traditional religiosity. And perhaps nondoctrinally religious therapists see their conventionally religious patients as possessing those same bases of faith and hope that improve therapeutic prognosis.

The results of this study do not easily lend themselves to

generalizations. Therapists' harsher judgments of religious patients may correspond in part to accurate clinical judgment. Traditionally religious patients may be initially more resistant to entering into a collaborative, open-ended therapeutic inquiry (Lovinger, 1984) and hence require more sessions. Religion may be a neutral or potentially amerliorating factor in the treatment of many depressed patients (Ostow, 1970), but a complicating one in the treatment of obsessive compulsives (Cohen and Smith, 1976). And assuming that prognosis affects outcome, one would recommend that religious patients seek therapy with a nondoctrinally religious therapist. However, this suggested therapist will not be recognizable by whether or not he or she attends church, or even whether or not he or she believes in God.

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